

FILED FEB 7 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1949

State File No. ....

BIRTH NO. <u>59902-50</u>		REG. DIST. NO. <u>241</u>		PRIMARY REG. DIST. NO. <u>5829</u>		Registrar's No. <u>4</u>	
1. PLACE OF DEATH a. COUNTY <u>New Madrid</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Portage</u> c. LENGTH OF STAY (in this place) d. FULL NAME OF HOSPITAL OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>New Madrid</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Portage Twp</u> d. STREET ADDRESS (If rural, give location) <u>Portageville</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>May</u> b. (Middle) <u>Frances</u> c. (Last) <u>Taylor</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 20, 1951</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Black</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u>		8. DATE OF BIRTH <u>Sept 2, 1950</u>		9. AGE (In years last birthday) <u>4</u>		10. IF UNDER 1 YEAR Months <u>18</u> Days <u>18</u> Hours <u>18</u> Mins.	
11. BIRTHPLACE (State or foreign country) <u>Portageville, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>Charley Taylor</u>		13b. MOTHER'S MAIDEN NAME <u>Robbie Haynes</u>	
14. NAME OF HUSBAND OR WIFE <u>✓</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Charley Taylor - Portageville, Mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>No Medical Attendant</u> ANTECEDENT CAUSES Ascribed conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Infant all round child</u> DUE TO (c) <u>Child from suffocation</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>under cover in bed.</u>		19. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>072</u>		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.		23. SIGNATURE (Degree or title) <u>Edith H. Smith, Coroner</u>	
23a. ADDRESS <u>New Madrid, Mo.</u>		23b. DATE SIGNED <u>1/20/51</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan 21, 1951</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		24d. LOCATION (City, town, or county) (State) <u>Conran, Mo</u>		DATE REC'D BY LOCAL REG. <u>Jan 20, 1951</u>		REGISTRAR'S SIGNATURE <u>Allen DeLisle</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Family</u>		ADDRESS		26. DATE OF DEATH <u>Jan 20, 1951</u>		27. TIME OF DEATH <u>072</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

FEB 6 1951

DISTRICT HEALTH OFFICE No. 6

File No. ....

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

*Not embalmed*

Student Embalmer No. ....

working under my personal supervision.

Student .....

Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.